In brief

Avian influenza deaths confirmed: China's Ministry of Health has asked for help from the World Health Organization after three cases of pneumonia of unknown cause in Hunan province, one of which was fatal. The authorities have previously denied that the death was caused by bird flu. Two more fatal human cases of H5N1 avian flu in Indonesia in October have been confirmed by laboratory tests in Hong Kong.

Netherlands flu plans inadequate: The Netherlands is not yet ready to tackle a flu pandemic, says its own health inspectorate. Preparations in more than half the Dutch regions are "unsatisfactory," and those of Zeelandare so inadequate that a pandemic would pose a "grave risk to public health." Problems include a lack of hospital beds and no guidance on distributing antiviral medication.

Drug trials fail to include enough women: Researchers are failing to spot sex specific side effects because too few women are recruited into clinical trials. Julia Lewis of Vanderbilt University told the American Society of Nephrology's annual meeting in Philadelphia that eight out of 10 drug licence withdrawals in the United States were related to unexpected side effects in women.

Sonic boom flights grounded: The Israeli Air Force has suspended "for the time being" a week of flights over Gaza during which they created sonic booms in the hope of deterring the dispatch of Palestinian mortars and rockets into Israeli territory. The flights were criticised by the Palestinian health ministry for causing miscarriages and heart problems.

Two star trusts in with a chance: NHS trusts rated as having two star status will be able to submit applications to have foundation status, England's health secretary, Patricia Hewitt, has announced. Until now trusts needed three stars to apply.

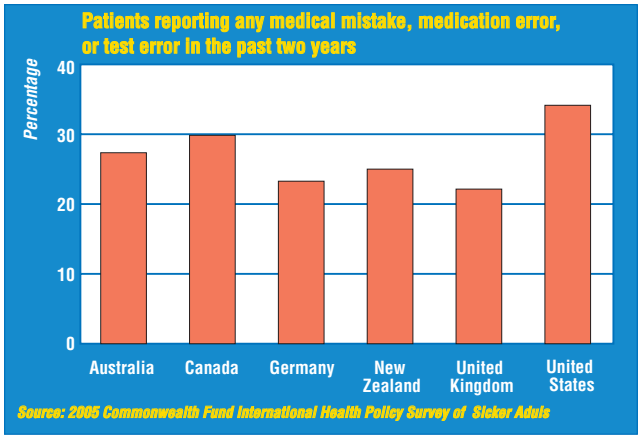
US has most reports of medical errors

Barbara Kermode-Scott *Calgary*

Developed countries around the world urgently need to tackle coordination of care, safety issues, medical errors, and communication in their healthcare systems, a new international survey has found.

The survey, from the Commonwealth Fund, a private foundation supporting independent research on health and social issues, evaluated the experiences of patients in Australia, Canada, Germany, New Zealand, the United States, and the United Kingdom. More than 2200 adults who had recently been hospitalised, had surgery, or had health problems were interviewed by telephone between March and June 2005 in the final study.

The authors found that all of the countries that they surveyed had high rates of failure to coordinate care during transitions, a lack of support for chronically ill patients, inadequate communication, and safety risks. Although they concluded that no country emerged as a clear winner or loser, the United States stood out for high error rates, inefficient coordination of care, and high out of pocket costs, leading to barriers to access to care.



Patients in America were the most likely to report medical errors, and patients in the UK were the least likely to report safety blunders. A third (34%) of US respondents reported at least one of four types of errors. They believed that they experienced a medical mistake in treatment or care, were given the wrong medication or dose, were given incorrect test results, or experienced delays in receiving abnormal test results. Three in 10 Canadian respondents reported at least one of these errors, as did a fifth or more of patients in Australia (27%), New Zealand (25%), Germany (23%), and the UK (22%).

"The findings show that we have a lot to learn from our colleagues," said Carolyn Clancy, director of the US Agency for Healthcare Research and Quality. □

Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries is at http://content.healthaffairs.org.

UK patient safety is improving

Rebecca Coombes *London*

Patient safety in the NHS has improved, but problems remain in areas such as the under-reporting of deaths and serious incidents caused by errors, the National Audit Office reported last week.

The study, based on surveys of NHS trusts, also found that not enough was being done to share lessons and solutions that had been learnt from previous adverse events. As many as half of the incidents in which NHS patients are unintentionally harmed could be avoided if lessons were properly shared, the watchdog concluded.

Previous studies have shown that about 10% of patients have an adverse event. Of these, about 60% are judged to cause low or no harm.

A Safer Place for Patients reports on findings from 256 NHS acute, ambulance, and mental health trusts. The National Audit Office found a year on year increase in incidents related to patient safety—a trend it put down to the drive to encourage staff to report adverse events.

According to the surveys, patients reported about 980 000 incidents and near misses in 2004-5. The estimated cost to the NHS of these incidents is some £2bn ($3.5bn; €3bn) a year. Falls and injuries were the most common incidents to be reported. But staff see this as having no direct link to the quality of care provided, the National Audit Office said.

But under-reporting was still significant for deaths and serious incidents—events that staff were more concerned to report. The office estimated that 22% of incidents went unreported—mainly medication errors and incidents leading to serious harm.

The watchdog estimated that 2181 deaths were recorded as a result of safety incidents in 2004-5. This is significantly higher than the National Patient Safety Agency's estimate of 840 deaths for the same year.

There had been improvements in encouraging doctors to report adverse incidents. This group is seen as most likely to overlook the need to do so. Some trusts had, as part of their performance management regimes, introduced a review of doctors' attitudes towards patient safety and evidence of reporting adverse events.

Other findings include:

- Progress in reducing the blame culture, although the office's survey heard complaints from nurses and other non-medical staff that it still predominates in some trusts
- Poor communication with patients still occured. Six per cent of trusts did not inform patients that they had been involved in a reported incident. □

A Safer Place for Patients: Learning to Improve Patient Safety is available at www.nao.org.uk.